Medwork Independent Review
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
WORKERS' COMPENSATION - WC

DATE OF REVIEW: 4/30/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Second Opinion – Cardinal Pain

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Physical Medicine and Rehabilitation/Pain Medicine

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY:
This reveals that this claimant has neck pain radiating into both shoulders, worse on the left side. Physical examination reveals restriction range of motion, tenderness to palpation, weakness in the left upper extremity, reflex changes and sensory loss in the left upper extremity. The physician's opinion on that day is that the claimant gets neurosurgical consultation for clearance of the intervention described as selective nerve root block using a VersaCath with a posterior approach is not a good idea and that if they decided to change from their current treating physician, that he would modify the analgesic regimen.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The letter from the claimant's wife, dated March 17, 2014, was read. She states in this letter that the treating provider, does not perform injections and 1 of the reasons they are looking for a 2nd opinion is that they would prefer the treating pain management provider also be the 1 performing the injections. Additionally, it appears there were some issues with the physician being out of town and not available for a follow-up/evaluation. In regard to the claimant's medical situation, it appears that he has had 3 spinal cervical surgeries and has what appears to sound like adjacent

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segment disease at C3-4 based on an MRI from 2012. This is per the notes. It appears that this stenosis of C3-4 is 7 mm which is significant central canal stenosis. It is appropriate that the physician performing the injections also be the one evaluating the patient, particularly in the situation where there is significant central canal stenosis with potential for neurologic deficit if there is mass effect on this level when injecting. It is reasonable what the physician has asked, which would be neurosurgical clearance for the injection. In this scenario, this claimant has 1 of 2 options including further surgical intervention which would likely be a fusion based on what appears to be other levels fused versus an injection that could potentially prevent further surgery. He does have neurologic deficit and active cervical radiculopathy and thus, has met criteria per official disability guidelines to have the injection. The 2nd opinion is reasonable and medically necessary for these reasons, particularly when trying to avoid or circumvent a further surgical intervention. Therefore, the denial for these services is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**